Additional Treatment Plan (Form)
(Confidential)

State of California **Additional Treatment Plan** VCGCB-VOC-6025 *(Revised 04-08-08)*	**California Victim Compensation and Government Claims Board (www.vcgcb.ca.gov)**

Return Form To: **Victim Compensation Program** **P.O. Box 942003** **Sacramento, CA 94204-2003** Or Fax to: **1-866-902-8669**	Application Number:	Date Form Sent:
	Victim's Name:	
	Claimant's Name:	
	Incident Date:	

Please submit this form if your client is within **eight (8)** sessions, or has reached the mental health benefit service limitations noted below and additional treatment is necessary as a direct result of the crime for which the Victim Compensation Program application was filed. (If you are the continuing therapist, please include a copy of your initial Treatment Plan.) **The Victim Compensation Program is unable to authorize additional sessions until the Additional Treatment Plan is reviewed and approved.** Further information, such as session notes or objective assessments of impairment, may be needed to evaluate this request for additional treatment. You will be notified by mail of the result of the review.

As required by law, the information requested must be returned to the Victim Compensation Program within ten (10) business days from the date of the cover letter and must be provided at no cost to the client, the Victim Compensation Program, or local Victim/Witness Assistance Centers. The Victim Compensation Program certifies that there is a signed authorization on file for the release of the information requested. Please answer questions fully and complete the signature page at the end of the document. You may use additional pages if necessary.

Mental Health Benefit Service Limitations
(For applications received on/after 01-24-06)

Service Limitation	Client/Patient
40 Session Hours	Direct Victim
30 Session Hours	*Direct Victim of Unlawful Sexual Intercourse *(Penal Code, section 261.5(d))* Derivative Victim who is a surviving parent, sibling, child, spouse, registered domestic partner, or **fiancé (fiancée) of a victim who becomes deceased due to the crime *Derivative Victim who was a minor at the time of the crime Derivative Victim who was one of two primary caretakers of a direct victim who was a minor at the time of the crime **** Not to exceed the statutory $3,000 outpatient mental health limit for applications received prior to 01-01-08*** *** Must have witnessed the crime*
15 Session Hours	*Derivative Adult Victim ** A derivative victim who does not meet any of the benefit limits listed above*

1. Name of Client:	
2. Name of Victim:	
3. Client's Relationship to Victim:	
4. Name of Therapist:	Provider Organization Name (if applicable):
5. License/Registration Number and Expiration Date:	

6. Mark Appropriate Box for Title of Licensed/Registered Therapist:

☐ LMFT ☐ Registered Psychologist ☐ LMFT Intern
☐ LCSW ☐ Resident in Psychiatry ☐ ASW
☐ Licensed Clinical Psychologist ☐ Registered Psychological Assistant ☐ Other (Please specify):
☐ Psychiatrist

7. Name and Title of Supervising Therapist (If applicable):

License Number: Expiration Date:

8a. What type of crime is the client being treated for?

☐ Assault With a Deadly Weapon ☐ Domestic Violence ☐ Child Abuse/Molest ☐ Sexual Assault ☐ Robbery
☐ Driving Under the Influence ☐ Hit and Run ☐ Homicide
☐ Other _____

8b. What is your present understanding of the details of the crime for which you are providing treatment?

9. If this victimization was not within the last 6 months, please describe the event(s) that brought the client into treatment at this time and describe how the event(s) are related to the qualifying crime.

If your client is a derivative victim (except a derivative of a direct victim who becomes deceased due to the crime), please skip to question # 23.

10. Please evaluate this client with respect to the criteria in the current **Diagnostic and Statistical Manual of Mental Disorders (DSM).** Evaluate on all 5 axes. Please complete this section as fully and accurately as possible.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

11. **If this client is six years of age or older**, please evaluate him or her on the Social and Occupational Functioning Assessment (SOFA) scale that is discussed in the current DSM. (Note: Rate the relational unit in which he or she resided at the time of this report.) Score:_____. ☐ N/A - Client is under 6 years of age.

12. Please evaluate the client on the Global Assessment of Relational Functioning (GARF) scale that is discussed in the current DSM. (Note: Rate the relational unit in which this client resided at the time of this report.) Score: _____.

13. If you are the **continuing therapist**, and the current impairment scores are lower than the scores on your previous Treatment Plan(s), please explain. ☐ N/A - New Therapist

14. Please describe any factor(s) not already noted which you believe may have a significant impact on the course of your treatment of this client:

15a. **TREATMENT PLAN**

If you are the **continuing therapist**, please indicate the overall percentage of treatment completed _____.

☐ N/A - New Therapist

15b. If you are the **continuing therapist**, please rate the status of the client's symptoms/behaviors, as shown on your previous Treatment Plan, on a scale from 1 to 9, with 1 representing the lowest score and 9 the highest.

Worsened			Remained Relatively the Same			Improved		
1	2	3	4	5	6	7	8	9

Symptom/Behavior: Rating:

Symptom/Behavior: Rating:

Symptom/Behavior: Rating:

Symptom/Behavior: Rating:

15c. If you are a **new therapist (or the continuing therapist treating additional symptoms/behaviors)** what symptoms/behaviors will be, or have been, the focus of your treatment?

Symptom/Behavior: Intervention:

Symptom/Behavior: Intervention

Symptom/Behavior: Intervention

Symptom/Behavior: Intervention

16. Have you, or do you plan to use any standardized, objective measures to assess the progress of your client's treatment?

☐ No ☐ Yes. Please specify the tests you expect to use:

17. What changes in the treatment plan, or client's circumstances, would improve the likelihood of the client's recovery?

☐ N/A – New Therapist

18. Has this treatment plan been discussed with and consented to by the client or the client's caretaker?
☐ Yes ☐ No

19. Date your treatment began:_____ Most recent date of treatment:_____

Has treatment terminated? ☐ Yes ☐ No

Number of sessions completed: Individual _____ Family: _____

Group: _____ Conjoint: _____

20. Did, or will, this client testify in any criminal or dependency proceeding related to the qualifying crime?
☐ Yes – If "yes", please provide the date of the court proceeding: _____/_____
☐ No (Month) (Year)

21. Was the perpetrator of the crime released from custody?
☐ Yes – If "yes", please provide the date the perpetrator was released from custody: _____/_____
☐ No (Month) (Year)
☐ N/A

22. If this client is a minor, is there a primary caretaker(s) involved in the treatment? ☐ Yes ☐ No ☐ Not a minor
If yes, please explain the nature and extent of involvement?

Complete questions 23 through 27 <u>only</u> if your client is a derivative victim (except a derivative of a direct victim who becomes deceased due to the crime).

23. Please describe why the treatment you are proposing is necessary for the recovery of the *direct victim*(s):

24. What symptoms/behaviors exhibited by the *direct victim* will be the focus of your treatment for your client?

25. What intervention(s) do you plan to address for each of the symptoms/behaviors described above?

26. Please describe the arrangements you have made in coordinating this treatment with the treatment being provided to the *direct victim*:

27. Did, or will, this client testify in any criminal or dependency proceeding related to the qualifying crime?
☐ Yes – If "yes", please provide the date of the court proceeding: _____/_____
☐ No (Month) (Year)

DECLARATION

CLIENT NAME: _____ APPLICATION NUMBER: _____

If the victim's offender is convicted, the Victim Compensation Program will request the criminal court to order the offender to pay restitution to reimburse the Victim Compensation Program for any expenses the Victim Compensation Program has paid for this crime. As a treating therapist you must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary as a direct result of the crime at the percentage indicated below.
Please Note: ***The Victim Compensation Program can only pay for the percentage of treatment that is necessary as a direct result of the crime for which the application was filed.***

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

- ☐ 0 %
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%
- ☐ Other: _____%

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Victim Compensation Program or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under *Government Code section 12651* for filing a false claim with the State of California and/or guilty of a misdemeanor or felon (pursuant to Penal Code Section 72), punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

I understand that mental health counseling must be approved in advance, and that if treatment is provided without the required approval, the Victim Compensation Program may not reimburse those expenses.

IMPORTANT – You MUST Provide The Required Signature(s) Below

Treating Therapist:

Name: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

If Registered Intern:

Supervising Therapist's Name: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

Tax Identification Number of person or organization in whose name payment is to be made:

_____

If you would like to be contacted by email when possible, please enter your email address below (optional).

_____

Clear Form **Print Form**